Providence
Medicare Advantage Plans

2024 Summary of Benefits

Providence Medicare Flex Group Plan + Rx (HMO-POS), an Oregon Public Employees Retirement System (PERS) employer group plan, offered by Providence Health Assurance

January 1, 2024 – December 31, 2024

This plan is available in Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark, Snohomish, and Spokane counties in Washington.

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When You Join Providence

You are not just part of an insurance policy but part of a community of care, focused on your health and well-being. This Summary of Benefits is provided to help you make the right health care decisions. It is a short guide of what we would cover and what you would pay if you joined our Providence Medicare Flex Group Plan + Rx (HMO-POS). To be clear, this is not a complete breakdown of benefits, and will not list every service that we cover, nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C and Part D benefits.

For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by visiting **ProvidenceHealthAssurance.com/PHIP** or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan Overview

Providence Health Assurance is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Health Assurance depends on contract renewal.

Not only do our plan members get all of the benefits covered by Original Medicare, they also get some extra benefits outlined in this summary.

Who Can Join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark, Snohomish, and Spokane counties in Washington.

Get In Touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

- If you're a member of this plan, call us toll-free at 1-800-603-2340 (TTY: 711)
- If you're not a member of this plan, call us toll-free at 1-855-210-1587 (TTY: 711)
- You can also visit us online at **ProvidenceHealthAssurance.com/PHIP**

Helpful Resources

- Visit **ProvidenceHealthAssurance.com/findaprovider** to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit **ProvidenceHealthAssurance.com/PHIP**, or give us a call for a printed copy.
- To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at **www.Medicare.gov** or request a printed copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Providence Medicare Flex Group Plan + Rx (HMO-POS)

Monthly Plan Premium	Your coverage is provided through a contract with your employer or former employer or union. Please contact the employer or union's benefits administrator for information about your plan premium. In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	$0 There is no medical deductible for in- or out-of-network services.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) for this plan:	
	In-network: $3,000	Out-of-network: $3,000 combined

Benefits		In-Network	Out-Of-Network
Inpatient Hospital Coverage[1]		$125 copayment each day for days 1-4 and $0 copayment each day for day 5 and beyond	20% of the total cost per stay
Outpatient Hospital Coverage[1]		$150 copayment for outpatient surgery at a hospital facility	20% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$150 copayment for outpatient surgery at an Ambulatory Surgical Center	20% of the total cost
Doctor Visits	Primary Care Provider Visit	$20 copayment	$30 copayment
	Specialist Visit	$25 copayment	$35 copayment
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing	
Emergency Care		$65 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.	
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.	

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. For 2024, referrals are no longer required for in-network specialists visits and Medicare-covered services.

[1] Services may require prior authorization. See Evidence of Coverage for more information.

Providence Medicare Flex Group Plan + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	10% of the total cost	20% of the total cost
	Therapeutic Radiology Services[1]	10% of the total cost	20% of the total cost
	Outpatient X-rays	10% of the total cost	20% of the total cost
	Diagnostic Tests and Procedures[1]	$0 copayment	20% of the total cost
	Lab Services[1]	$0 copayment	20% of the total cost
Hearing Services	Medicare-Covered	$25 copayment	$35 copayment
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$399 copayment per Advanced hearing aid or a $699 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[1]	$25 copayment	$35 copayment
Vision Services	Medicare-Covered Exams/Screening	$25 copayment per exam $0 copayment for glaucoma screening	$35 copayment per exam $0 copayment for glaucoma screening
	Routine Exam	$20 copayment for one exam per calendar year with a qualified licensed provider	
	Medicare-Covered Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $200 every two calendar years for any combination of routine prescription eyewear	

[1] Services may require prior authorization. See Evidence of Coverage for more information.

Providence Medicare Flex Group Plan + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Mental Health Services	Inpatient Visit[1]	$125 copayment each day for days 1-4 and $0 copayment each day for days 5-90	20% of the total cost per stay
	Outpatient Individual[1] and Group Therapy Visit[1]	$25 copayment	$35 copayment
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $50 copayment each day for days 21-100	20% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$25 copayment	$35 copayment
Ambulance[1]		$50 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		0% - 20% of the total cost (Insulin cost share up to $35 per month)	0% - 20% of the total cost (Insulin cost share up to $35 per month)
Medicare-Covered Foot Care (podiatry services)		$25 copayment	$35 copayment
Medical Equipment and Supplies	Durable Medical Equipment and Supplies[1]	20% of the total cost	20% of the total cost
	Prosthetic Devices[1]	20% of the total cost	20% of the total cost
	Diabetic Supplies[1]	$0 copayment	20% of the total cost
	Diabetic Therapeutic Shoes or Inserts[1]	$0 copayment	20% of the total cost
Wellness Program		$0 copayment for monthly gym membership with participating fitness clubs	

[1] Services may require prior authorization. See Evidence of Coverage for more information.

Prescription Drug Benefits

Providence Medicare Flex Group Plan + Rx (HMO-POS)

Prescription Drug Deductible	
Yearly Deductible (Applies to all tiers)	There is no prescription drug deductible for this plan.

Initial Coverage	You pay the following until your yearly out-of-pocket costs reach $5,000. You may get your drugs at retail pharmacies and mail-order pharmacies.

Retail and Mail-Order Cost Sharing			
	Up to 31 days	**Up to 62 days**	**Up to 93 days**
Tier 1 (Preferred Generic)	**Retail and Mail:** Up to an $8 copayment	**Retail and Mail:** Up to a $16 copayment	**Retail:** Up to a $24 copayment **Mail:** Up to a $16 copayment
Tier 2 (Generic)	**Retail and Mail:** Up to a $15 copayment	**Retail and Mail:** Up to a $30 copayment	**Retail:** Up to a $45 copayment **Mail:** Up to a $30 copayment
Tier 3 (Preferred Brand)	**Retail and Mail:** 40% up to $250 max.	**Retail and Mail:** 40% up to $500 max.	**Retail and Mail:** 40% up to $750 max.
Tier 4 (Non-Preferred Drug)	**Retail and Mail:** 40% up to $250 max.	**Retail and Mail:** 40% up to $500 max.	**Retail and Mail:** 40% up to $750 max.
Tier 5 (Specialty)	**Retail and Mail:** 40% up to $250 max.	Not offered	Not offered

Prescription Drug Benefits

Providence Medicare Flex Group Plan + Rx (HMO-POS)

Out-Of-Network Cost Sharing			
	Up to 31 days	**Up to 62 days**	**Up to 93 days**
Tier 1 (Preferred Generic)	Up to an $8 copayment plus any difference in the cost if you were to have used a standard pharmacy	Not offered	Not offered
Tier 2 (Generic)	Up to a $15 copayment plus any difference in the cost if you were to have used a standard pharmacy	Not offered	Not offered
Tier 3 (Preferred Brand)	40% of the total cost plus any difference in the cost if you were to have used a standard pharmacy, up to a maximum of $250	Not offered	Not offered
Tier 4 (Non-Preferred Drug)			
Tier 5 (Specialty)			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy but may pay more than you pay at a preferred in-network pharmacy.

Coverage Gap (Applies to all tiers)	Because there is no coverage gap for the plan, this payment stage does not apply to you.
Catastrophic Coverage (Applies to all tiers)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay $0 for the remainder of the calendar year.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。